

Mental Retardation Community Medicaid Services

INDIVIDUAL SERVICE PLAN

MR Case Management - 90 DAY SCREENING

Code number: _____

Individual: _____ Medicaid Number: _____

CSB: _____ Provider Number: _____

Case Manager: _____ Telephone: _____

Start Date: _____ End Date:** _____ Quarterly Review Dates: N/ACASE MANAGEMENT GOAL: *To determine if _____ is eligible for Targeted Case Management Services.*

CASE MANAGEMENT OBJECTIVES (Examples in italics. Delete any that do not apply. Add any additional on page 2.)	TARGET DATE	ACTIVITIES/ STRATEGIES (Examples in italics. Delete any that do not apply. Add any additional on page 2.)
<p>1) <i>Determine eligibility.</i></p> <p>If eligible, continue. If ineligible, cease Medicaid billing and issue a Right to Appeal letter.</p> <p>2) <i>Determine the need for active Case Management.</i></p>		<p><i>Meet with _____ (and family member(s)/caregiver when appropriate) to discuss needed supports. Start date is the date of the first face-to-face meeting.</i></p> <p><i>Review financial situation and assist _____ in applying for SSI and Medicaid, if applicable.</i></p> <p><i>Obtain a new or previously completed psychological evaluation that reflects current functioning.</i></p> <p><i>Obtain supporting documentation from other sources: medical, development assessment, school records, etc.</i></p> <p><i>Determine with _____ or family member(s)/caregiver if the needed frequency and level of case management requires at least a monthly activity.</i></p>

CASE MANAGEMENT GOAL: *To determine _____'s service needs.*

<p>3) <i>Coordinate the assessment of _____'s current situation and strengths in major life areas and determine service and supports needed within the community.</i></p>		<p><i>Complete the Social Assessment. Assure preferences and interests are included.</i></p> <p><i>Complete other formal/informal assessments needed to determine any other case management needs.</i></p> <p><i>Meet with _____ or family member(s)/caregiver to review results of assessments, set personal goals, and identify supports needed. Develop an annual CM ISP.</i></p>
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Individual _____ Date _____

<p>4) <i>Complete required documentation and maintain in _____'s CM record.</i></p> <p>(NOT A BILLABLE ACTIVITY, IN AND OF ITSELF)</p>		<p><i>Complete per-contact documentation regarding monthly activity(s).</i></p>
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**Attach a signature page that includes, at a minimum, the signatures of the individual/legal guardian and the provider's responsible staff member.*

**** End date cannot exceed 90 calendar days; billing restricted to no more than 3 calendar months.**